Dear traveller – vaccinations should be given at least 2 months before you travel. This form should be completed and handed in to reception at least 1 week before your appointment with the nurse.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  |  |  | Date of birth |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Male□ | Female □ |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| E mail: |  |  |  | Telephone number: |  |  |  |  |
|  |  |  |  | Mobile number: |  |  |  |  |
| **PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW** |  |  |  |  |
| Date of departure: |  |  |  | If flying, how many hours is the flight to your destination:  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **COUNTRY TO BE VISITED** |  | **EXACT LOCATION OR REGION** | **CITY OR RURAL** |  | **LENGTH OF STAY** |  |
| 1. |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Have you taken out travel insurance for this journey? |  |  |  |  |  |  |  |
| Do you plan to travel abroad again in the future? |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
| **TYPE OF TRAVEL AND PURPOSE OF TRIP- PLEASE TICK ALL THAT APPLY** |  |  |  |  |
| □ Holiday | □ Staying in hotel | □ Backpacking |  |  | Additional information |  |
| □ Business trip | □ Cruise ship trip | □ Camping/hostels |  |  |  |  |  |
| □ Expatriate | □ Safari | □ Adventure |  |  |  |  |  |  |  |
| □ Volunteer work | □ Pilgrimage | □ Diving |  |  |  |  |  |  |  |
| □ Healthcare worker | □ Medical tourism | □ Visiting friends/family |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** |  |  |  |  |  |  |  |
|  |  |  |  |  | **YES** |  | **NO** | **DETAILS & DATES** |
| Are you fit and well today |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Any allergies including food, latex, medication |  |  |  |  |  |  |  |  |  |  |  |
| Severe reaction to a vaccine before |  |  |  |  |  |  |  |  |  |  |  |
| Tendency to faint with injections |  |  |  |  |  |  |  |  |  |  |  |
| Any surgical operations in the past, including e.g. your |  |  |  |  |  |  |  |  |  |
| spleen or thymus gland removed |  |  |  |  |  |  |  |  |  |  |  |
| Recent chemotherapy/radiotherapy/organ transplant |  |  |  |  |  |  |  |  |  |
| Anaemia |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bleeding /clotting disorders (including history of DVT) |  |  |  |  |  |  |  |  |  |
| Heart disease (e.g. angina, high blood pressure) |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Disability |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Epilepsy/seizures |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Gastrointestinal (stomach) complaints |  |  |  |  |  |  |  |  |  |  |  |
| Liver and or kidney problems |  |  |  |  |  |  |  |  |  |  |  |
| HIV/AIDS |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Immune system condition |  |  |  |  |  |  |  |  |  |  |  |
|  |  | **YES** | **NO** | **DETAILS & DATES** |
| Mental health issues (including anxiety, depression) |  |  |  |  |
| Neurological (nervous system) illness |  |  |  |  |
| Respiratory (lung) disease |  |  |  |  |
| Rheumatology (joint) conditions |  |  |  |  |
| Spleen problems |  |  |  |  |
| Any other conditions? |  |  |  |  |
| **Women only** |  |  |  |
| Are you pregnant? |  |  |  |  |
| Are you breast feeding? |  |  |  |  |
| Are you planning pregnancy while away? |  |  |  |  |
|  |  |  |
|  | **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
|  | **PLEASE SUPPLY DATES OF ANY VACCINES OR MALARIA TABLETS TAKEN IN THE PAST** |
|  |  |  |  |  |  |
| Tetanus/polio/diphtheria |  | MMR |  | Influenza |  |
|  |  |  |  |  |  |
| Typhoid |  | Hepatitis A |  | Pneumococcal |  |
|  |  |  |  |  |  |
| Cholera |  | Hepatitis B |  | Meningitis |  |
|  |  |  |  |  |  |  |
| Rabies |  | Japanese |  | Tick Borne |  |
|  | Encephalitis |  | Encephalitis |  |
|  |  |  |  |  |
| Yellow fever |  | BCG |  | Other |
|  |  |  |  |
|  |  |  |  |  |  |
| Malaria Tablets |  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Any additional information** |  |  |  |
|  |  |  |  |  |  |  |